Final Steering Committee Report

Submitted to:
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Submitted by:
Steering Committee: State Planning Grant on the Uninsured -- Continuation Grant 2005-2006

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I. INTRODUCTION

This group of 24 was appointed by the Director of the Department of Public Health and Human Services in the Fall of 2005 to oversee Montana's second State Planning Grant (SPG) efforts.

As noted on p. 38 of the continuation grant, the steering committee's charge was to:

a. Consider the data and information;
b. Provide opportunities for the public to comment;
c. Strengthen the relationships and improve coordination between public and private health insurance;
d. Improve state programs, policies, statutes, regulations to: assist small employers in accessing affordable coverage for their workers, encourage access for low-wage workers and the self-employed, modify or expand publicly-funded programs, improve access to affordable prescription drugs, and define other options to increase access.

Please see the picture on the following page that depicts some key points in history (since 1993), the more recent federally-funded work that began under the first of these grants starting in 2002, and then shows the state of Montana has committed to an interdepartmental agreement between DPHHS, Labor, and the Insurance Commissioner, and created a continuing home for health care policy at DPHHS to sustain, collect and use Montana-specific data to inform policy decisions.

This page intentionally blank: placeholder for visual diagram showing history, process, & desired future. Will be inserted in final that goes to Joan.

Not included in this e-copy because it's too big an electronic file for some personal computer systems! --

II. EXECUTIVE SUMMARY

Even though Montana continues to have one of the higher rates of uninsurance in the nation at 18.4%, it was one of the states that twice received a State Planning Grant from the federal Department of Health and Human Services to identify the state's uninsured and underinsured as well as to help evolve solutions to providing health care coverage to all Montana residents.

Prior to the receipt of the first State Planning Grant by the Montana Department of Public Health and Human Services (DPHHS) in 2002, Montana relied on extrapolating data from national and private sources to describe its uninsured population.

The results of that grant, including the series of recommendations on how to cover more of Montana's uninsured population are contained in two documents available on the **DPHHS website (www.dphhs.mt.gov/uninsured/index.shtml)**: the **Montana Strategic Plan to Provide More Affordable Health Care Coverage (Summary of the Montana State Planning Grant Recommendations August, 2004)** and the **Final Report to the Secretary Spring, 2004.**

In the fall of 2005 Montana was awarded a second state planning grant. The purposes of this continuation grant were to:
(1) analyze the impact of current legislative initiatives (that passed the 2005 Legislature) that expand health coverage for the uninsured; **(2)** develop sustainable methods to gather information about health insurance for the population in total and information related to employer-based health insurance; and **(3)**create a "home" for continuing health policy development that addresses providing health care coverage to all Montanans.

This continuation grant functioned under the guidance of a twenty four member Steering Committee (composed of private and public sector representatives) and the technical advice of a team of staff from DPHHS, the Department of Labor and Industry (DOLI) and the Insurance Commissioner's Office. In this document, the Steering Committee is proposing a series of specific short-and long-term actions that will lead to accessibility of affordable high quality health care coverage for all Montanans by the Year 2012.

Specifically the results of this grant will help Montana define ways to: **(1)** continue to refine and create a sustainable source of data on the insurance status of Montanans, including employer-based insurance; **(2)** analyze the impact of current policies and programs influencing access to health care coverage; and

(3) develop and recommend possible policy options for consideration by the Steering Committee in the following **long term policy guidance areas**: sustaining the infrastructure to regularly provide data on the uninsured; value and build the health care workforce; weave the integration of Native People into every action; **short term/possible immediate legislative areas:** expand coverage to target populations; promote cost avoidance through prevention; expand the safety net; expand pooling, and **other ideas for consideration (either long term or short term)** expand eligibility in public health care programs.

All the results from this continuation grant are available at the above referenced DPHHS website (**www.dphhs.mt.gov/uninsured/index.shtml).**

III. PRINCIPLES

The following 10 principles are the group's working principles – an amalgamation of the principles the SPG committee developed in August 2003 and August 3, 2006 insights recorded by the group. Each policy idea should be asked – does this:

1) Support and develop actions that increase access to health care, health care coverage and prevention?

2) Continue to gather and monitor data to keep track of intersecting systems and to inform actions and decisions?

3) Define the problem(s)?

4) Promote prevention and wellness to avert avoidable costs?

5) Maximize use of federal and state dollars and use methods to contain costs?

6) Pass the test of being fiscally responsible?

7) Keep it simple, administratively doable and practical for our sparsely populated, geographically large state?

8) Reduce existing system complexities?

9) Have basic benefits that are clearly defined that improve health status?

10) Cover those with the greatest need first?

IV. RECOMMENDATIONS

Here are the eight action arenas and 12 recommendations this group supports within each.

1. SUPPORT THE INFRASTRUCTURE.

Recommendation 1A is three Departments collaborating (DPHHS, Labor and Insurance Commissioner) to evaluate, monitor and sustain this work.

Recommendation 1B is a commitment to survey a cross section of Montana households every 2 years to monitor level of health insurance coverage.

2. VALUE/BUILD THE HEALTHCARE WORKFORCE.

This recommendation sets out strategies to educate, recruit and retain Montana's health care workforce.

3. WEAVE THE INTEGRATION OF NATIVE PEOPLE INTO EVERY ACTION.

This recommendation promotes recognition and acknowledgement of the government to government state-tribal relationship and then notes each action arena with specific considerations under each as they relate to Native peoples living in and out of Indian Country. The template also brings in aspects of House Bill 452 to highlight specific support for elements of this bill draft as well – which brought forward the results of previous state-tribal consultation on ways to redesign Medicaid.

4. EXPAND COVERAGE TO TARGETED POPULATIONS.

Recommendation 4A proposes funding required to purchase private employer-based health insurance for the currently uninsured, low-income workers who deliver in-home Medicaid personal assistance services, and for a small number of workers who provide Medicaid private duty nursing services.

Recommendation 4B proposes extending the age of dependent child coverage to age 26, regardless of the child's employment status or enrollment in education, enabling parents to continue coverage of their children in their family's health plan.

5. AVOID COSTS THROUGH PREVENTION.

Recommendation 5A proposes funding two local public health departments to act as pilot referral sites on primary prevention of chronic diseases.

Recommendation 5B proposes integrating incentive-based wellness into employer based health insurance, first for State of Montana employees.

6. EXPAND COMMUNITY HEALTH CENTERS.

This recommendation proposes assisting Montana communities to expand services and delivery sites through existing and new Montana Community Health Centers.

7. EXPAND POOLING.

This recommendation proposes continued support for Insure Montana – a joint initiative of Governor Brian Schweitzer and State Auditor John Morrison to assist small businesses with the cost of health insurance.

8. EXPAND CHIP AND MEDICAID FPL.

Recommendation 8A proposes expanding CHIP (Childrens Health Insurance Program) eligibility to 200%.

Recommendation 8B proposes standardizing Children's Medicaid to 133% Federal Poverty Level.

Recommendation 1A: Three Departments to Support the Infrastructure

Maintain and support the infrastructure, by:

1. developing an interagency agreement among the three lead agencies (DPHHS, DOLI and the Insurance Commissioner's Office) that:
   a. promotes an official state policy of "Health Care for All Montanans by 2020".
   b. provides a "home" for building solutions for Montana's uninsured and underinsured;
   c. continues soliciting the advice and guidance of the State Planning Grant (SPG) Steering Committee currently appointed;
   d. commits annual state or other funding for data collection on the state's uninsured; and,
   e. evaluates programs/products developed to provide health care to more Montanans.

Target Population

All Montanans (especially those who are without health care or without enough health care), including Native populations in Indian Country are the target population.

Montana continues to hold its status as having one of the higher rates of uninsurance in the nation. Current Census Bureau data shows that Montana's percentage of people without health insurance coverage from 2003-2004 (19.3% uninsured) to 2004-2005 (18.4%) has decreased slightly, but not significantly.

This particular grant is targeting (for recommendations) the uninsured who work for small employers, the uninsured who earn low wages and those who are self-employed.

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

As Montana residents, they are eligible to apply for public health care coverage programs and private health care coverage products and all Montana residents' needs will continue to be evaluated through the survey structure.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

To date Montana's approach to solving the problem of the uninsured has been to "patch" together a variety of solutions.

Subsequent to the end of the first SPG, this approach was exemplified when Montana's 2005 Legislature implemented many of the recommendations from the

first SPG and passed legislation (and the Governor signed into law) seven initiatives (beginning in January, 2006) that are proposed to provide coverage to another 100,000 Montanans. Examples of these initiatives are:

- CHIP expansion projecting to bring another 3,000 children on CHIP;
- Children's asset limit increased to $15,000 anticipating an increase of another 4000 Medicaid kids, and leveraging more available CHIP slots;
- Insure Montana Program allowing for tax credits, premium payments and purchasing pools that will increase the number of insured Montanans by 7300;
- Premium assistance for approximately 20,000 low income Montanans;
- Discount prescription drug program for approximately 60,000 Montanans; and
- The HIFA Waiver giving either benefits or premium assistance (to buy employer-based insurance products) for up to approximately 4500 Montanans.

Some of these efforts were strictly available through the public sector and some were products of a private public partnership.

Identifying the take-up rate in the private sector has not been possible because there has been an inconsistent and limited attempt to document if individuals who are now buying health insurance have had health insurance immediately prior.

It is anticipated that the continued approach to solving the problem will be through using the expertise and guidance of a Steering Committee to advise and provide guidance on how to patch or piece together more ideas for covering more people either through public sector or private sector or a mix of the two. It is also anticipated that such ideas will be presented to both the executive and legislative branches for formalization and implementation.

Administrative Issues

Especially with the ending of the federal State Planning Grant authority, the success of this recommendation will depend on the level of commitment by the three agencies (mentioned above) necessary to keep this health policy guidance and initiative planning effort ongoing.

With the placement of this effort in the DPHHS Office of Planning, Coordination and Analysis, staff time within that office will have to be allocated to continue at least the survey administration, program evaluation, and solicitation of advice from convening the existing Steering Committee at least twice a year to evolve health policy for Montana.

Cost

Refer to administrative issues above. Costs associated for this would be to conduct the surveys, analysis of the survey results, reconvening the Steering Committee and staff time associated with these functions.

Estimated costs are:
$15,000 Department of Labor and Industry (DOLI) Survey
$15,000 Behavioral Risk Factor Surveillance Survey (BRFSS)
$3,000 DPHHS Office of Planning, Coordination and Analysis
$2500 Steering Committee Meeting/s
$35,500 TOTAL

Funding Sources

General and federal funds would need to be designated for this activity within current existing budgets. Federal match may be available, depending on the activity.

Implementation

- Official designation of DPHHS Office of Planning, Coordination and Analysis;
- Formulation of formal agreement among three state agencies (DPHHS, DOLI and State Auditor's Office);
- Administration of BRFSS and DOLI Employer Survey;
- Convening of Steering Committee to provide survey feedback and solicit as well as suggest health policy directions; and
- Development of legislative initiatives to provide adequate health care coverage to more Montanans.

Recommendation 1B: Survey Montana Households Every Two Years

Survey Montana households every two years to monitor the level of health insurance coverage and to collect data on the financial and other effects of health insurance status.

Target Population

The target population is a cross section of Montana adult residents.

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

These populations would be included in the survey as they were previously.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

The number of people who have no health insurance in Montana through previous studies has been determined. But, how many people with insurance have coverage that helps to pay for primary and preventive care? How many people have "catastrophic only" policies? Is the sale of these policies increasing? How many have policies with high deductibles and co-pays? How does this impact their health care choices and decisions? Are they receiving their health screenings? How does this impact their household finances? Do they put off getting the care they need? How does this impact the state of their health? Are these out-of-pocket costs going up every year? What is the household medical debt? Is it getting worse? Where are they getting medical/dental care? Is it easier or more difficult to access?

Montana policy makers need good data to make good policy decisions.

Administrative Issues

DPHHS will contract with the University of Montana (U of M) Bureau of Business and Economic Research (BBER), the entity who developed and completed the previous surveys. It is preferable to use an in-state entity – people are more likely to answer the questions if it is the University calling. Also, U of M understands the local calling patterns (eg. cellphones, reservations).

Cost

Approximately $50,000 per survey year

Funding Sources

This will be left to the discretion of the Montana DPHHS Director.

Implementation

Utilize the experience and expertise of the U of M Bureau of Business and Economic Research. Develop the questionnaire and pretest the tool. Survey 1,200 households. Repeat the household survey every two years for a period of six years. U of M will analyze data and write a report. The survey should be conducted during the off years of the state legislature so that the data is available for the next session.

Recommendation 2: Value and Build Montana's Healthcare Workforce

Target Population

All of Montana's healthcare workforce is the target population.

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

The workforce needs of Montana's healthcare delivery system include the delivery systems serving sovereign, tribal populations living in Indian Country and urban Native Americans.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

The success and value of the Montana healthcare delivery system depends on qualified personnel to deliver care. It is well known that access to care, quality of care and costs of care are affected by the availability of properly educated and trained healthcare providers. In consideration of this need, a group of organizations called the Montana Primary Care Liaison Group, developed the following recommendations**:**

- Develop and implement a comprehensive health care workforce communication plan that will provide effective communication between the healthcare industry, state agencies, public school systems, institutions of higher education, executive and legislative branches of the government and the public.

- Develop a comprehensive healthcare workforce data collection and analysis system that will be used for health systems planning, health professions shortage designations, recruitment and retention incentive programs, academic education planning, continuing education, research and policy making.

- Develop a Heath Care Workforce Steering Council which includes the appropriate state agencies and other stakeholders for the purpose of identifying and prioritizing workforce data needs, assessing the required expertise and funding resources and assisting in the dissemination and intelligent utilization of the data in policy making, education planning and research.

- Develop a comprehensive, efficient and effective system for collecting health professions data.

- Develop a comprehensive statewide system for health education program planning. The planning process must consider a variety of strategies including alternatives to new program development, new delivery models and educational pathways for health care providers, incentives to existing institutions to participate and comply with the plan, and increased communication between the Office of the Commissioner of Higher Education (OCHE) workforce development committee and health professions programs.

At its March 3, 2006 meeting the Board of Regents passed the following motion:

Regent Semmens moved approval to submit a Healthcare Workforce Training Initiative in the amount of $4.0 million that includes development of a healthcare worker strategic plan, creation of data and program Steering groups, implementation of physician recruitment recommendations, expansion of up to ten WWAMI medical school slots, and development and expansion of allied health programs to address critical shortage areas.

To follow up on the recommendations of the PCLG and the Board of Regents, a Montana Healthcare Workforce Advisory Committee was formed, with staff support donated by the Montana Office of Rural Health/Area Health Education Center. At the same time, the State Workforce Investment Board created a Healthcare Workforce Committee, staffed by the Office of the Governor and the Department of Labor and Industry. The two groups, with overlapping membership and a cooperative approach, will be developing recommendations on what Montana should do to assure an adequate workforce to assure access to healthcare. The State Planning Grant Steering Committee can:

- Provide data to inform actions and decisions on healthcare workforce strategies;
- Provide guidance on healthcare workforce shortages that are impacting vulnerable populations or increasing the cost of healthcare services;
- Provide guidance on healthcare workforce strategies that will increase access to healthcare, healthcare coverage, and focus on prevention; and
- Identify resources and expertise that will support health systems planning, health professions shortage designations, recruitment and retention incentive programs, academic education planning, continuing education, research and policy making

Administrative Issues

The complexity of addressing healthcare workforce issues requires a multi-agency approach in collaboration with higher education, healthcare associations, and the provider community. The State Planning Grant Steering Committee should consider designating formal liaisons to communicate among the healthcare workforce groups, to assure that the needs of uninsured, underinsured and vulnerable populations are considered.

Cost

Costs would be associated with data collection and analysis, staff support and for specific recommendations resulting from committee work. Recommendations related to expansion of healthcare programs (e.g. WWAMI, Dental WWAMI, nursing and/or allied health) can be provided

Funding Sources

Funding sources are not identified at this time.

Implementation

Implementation of projects associated with expansion of programs would be managed through the educational systems. Implementation of workforce planning would be managed through a cooperative approach of several state agencies, educational programs and healthcare associations.

Recommendation 3: State-Tribal Relationship and Compilation of how to Weave Natives into each Action Arena

This recommendation is a compilation of all SPG recommendations designed to create a specific section for the Native American population in the State. We believe this is necessary to ensure the acknowledgement and recognition of the unique needs of this population as well as the special relationship between State and Tribal Government.

Target Population

The State's Native American population is the target population.

SPG Recommendations included in this section:

- Expand CHIP enrollment by increasing income guidelines to 200% of Federal Poverty Level (FPL).
  - Outreach to uninsured, eligible Native American children below 200% FPL
  - CHIP will continue its focus on clarity for Native American families, the advantages of concurrent eligibility for Native American Health Service (IHS), and CHIP benefits.
  - CHIP has completed recent visits to all seven Tribal reservations and established contacts with IHS representatives as well as urban health centers. Training is being provided to Tribal Health staff regarding CHIP and the application process.
  - An insert in CHIP brochures explains benefits, eligibility, and the co-pay waiver for Native American children.
  - Annual reviews of CHIP activities within the Native American population are ongoing to improve and increase participation.

- Value and build Montana's healthcare workforce
  - The workforce needs of Montana's healthcare delivery system include the delivery systems servicing sovereign Tribal populations residing on and near Indian reservations as well as urban areas.
  - The primary health care provider for the Native American population is the IHS. Issues related to recruitment and retention of qualified properly educated and trained health care providers are apparent and indicated in the IHS health care delivery system. In addition, because the IHS utilizes health care providers in the

private sector for referrals for specialty care, the recommendation developed by the Montana Primary Care Liaison Group (see reference to this group in Recommendation #6) is important and applicable to the Native American population.

- Support efforts to develop more federally funded community health centers and expand medical, dental, and mental health services and delivery sites through existing Montana Community Health Centers.

  - Indian tribes or tribal Indian organizations under the Indian Self Determination Act or urban Indian organizations under the Indian Health Care Improvement Act are eligible to apply for federal community health center funds. Rules for state funding must define these groups as eligible, as well.

    In addition, community health centers should target Native American populations in their service area to access and provision of services. In areas where urban health centers exist (Billings, Butte, Missoula, Great Falls, Helena) community health centers should establish working relationships to meet the needs of eligible Native Americans.

- Survey Montana households every two years to monitor the level of health insurance coverage and to collect data on the financial and other effects of health insurance status.

  - Tribal populations living in Indian country and urban Native Americans will be included in the surveys.
  - Data available through Tribal Health Departments and IHS should be used and made a part of the reports.
  - Tribal populations residing within reservations have more defined efforts and/or activities to gather information that could be different and specific to the communities. This could be discussed further for possible alternatives.

- Maintain and support the infrastructure by:

  1. Developing an interagency agreement among the three lead agencies (DPHHS, DOLI, and the Insurance Commissioners Office) that:

     - Promotes an official State policy of “Health care for All Montana by 2020”;
     - Provides a “home” for building solutions for Montana’s uninsured and underinsured; and

- Continues soliciting the advice and guidance of the currently appointed Steering Committee.
- Commits annual State or other funding for data collection on the State's uninsured;
- Evaluates programs/products developed to provide health care to more Montanans; and
- Addresses the unique status and unique situation of the State's Native American populations both on the reservations and in urban settings.

- Raise income standard to 133%.

  - The Native American population is included in this recommendation.
  - This would increase Native American children eligible for Medicaid.
  - The State will benefit from the 100% FMAP for health care services provided by Tribes and Indian Health Services within Indian Health Services walls.

- Integrating wellness into employer based health insurance.

  - This includes Native American population
  - Data and information available through current IHS and Tribal preventive health programs/projects can be used to include in report.

- Primary prevention of chronic disease

  - This includes Native American population at high risk for diabetes and with multiple cardio metabolic risk factors (obesity, etc.).
  - Various statistics and reports indicate the serious problems in the Native American Population with diabetes prevalence and heart disease. Concentrated efforts and activities in this particular area are necessary.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

This focuses the goal of health care to all Native American Montanans.

Administrative Issues

Administrative issues are unidentified at this time.

Cost

The cost of this total effort is unknown at this time.

Funding Sources

Funding for this effort is not identified at this time.

Implementation

10-9-06 note from Garfield Little Light to the steering committee:

My thoughts on the strategy to do a separate recommendation for the Native American population (living on and near reservations and in urban areas) was not that we be treated differently but that consideration is given for some of the unique situations within our population and in the communities in Indian country. Additionally, the fact that the State and Federal governments have a unique relationship with the Tribes in all aspects of Tribal activities, including health care, should be recognized and acknowledged in this report. Saying that, it is also necessary that recommendations which target the State population need to include the Native Americans as citizens of the State. I hope this is not terribly confusing. If it is, I can try to explain further at our next meeting. The importance of what I'm trying to say here is evident in the way this particular recommendation is crafted. In some ways, the specific needs and situations in Indian country and urban areas are identified AND also in other ways, recommendations for the general population are incorporated. As you can see, I used the template to convey this particular recommendation and also added the headings for each recommendation in our draft report and then added or changed some of them to include the specific items related to Native Americans. I did not utilize the whole template as it relates to headings such as; administrative issues, cost, funding source, etc., because I felt they would all apply to our population. I am not sure if this is the best way to do it but if there are ideas or suggestions I will appreciate it.

There are some other items I feel need discussion to get a broader perspective of our population that may or may not have relevance to the report but may be useful for the group to know. They are as follows:

- 100% FMAP for services provided to Native Americans on Medicaid who receive services in IHS/Tribal facilities. Are there opportunities to look at to benefit the State?

- CHIP, in addition to efforts in this report, are there opportunities for the State, IHS, and Tribes to create partnerships to meet the needs of Native American children?

- Should the role of IHS and Tribal Health programs be clarified in a section of the report to have a better understanding of health care available to the Native American population but not in the form of health insurance coverage, per se?

- There are studies and reports regarding barriers and obstacles of Native Americans accessing existing Federal, State, and local health programs. Not as a criticism but in a constructive way, can some of these findings be addressed in recommendations for this report?

These are a few things I wanted to bring to your attention as you review this recommendation and also share a little of what I was thinking and intentions were to see about how the Native American population can be woven into the recommendations.

Please let me know if any changes or improvements can be made. AHO! Garfield

Recommendation 4A: Healthcare for Montanans Who Provide Healthcare

This proposal addresses one way to leverage the federal Medicaid dollar to provide health care to a select group of employees in the private sector who work with Medicaid sponsored individuals.

Specifically this proposal outlines the funding that would be required to purchase private employer-based health insurance for the currently uninsured low-income workers who deliver in-home Medicaid Personal Assistance Services (PAS) such as meal preparation and assistance with dressing, bathing and eating to elderly Montanans and Montanans with disabilities, as well as insurance for a small number of workers who provide Medicaid Private Duty Nursing (PDN) services to the same population. Because Personal Assistance and Private Duty Nursing are Medicaid funded services, federal matching funds would finance approximately 70% of the additional cost of the new health insurance. The additional funding would be distributed by increasing the amount the Montana Medicaid program pays to those agencies that deliver PAS or PDN services who are willing to sign an agreement that commits them to providing their eligible employees with the required insurance. The reimbursement increase would be designated for the sole purpose of funding employee health insurance that meets a specific set of criteria established by the state. Participation in the insurance program by employers that provide PAS and PDN services would be totally voluntary.

Target Population: Uninsured Medicaid Personal Assistants and Private Duty Nurses

The proposal would make health insurance available to the estimated 1,700 people who work at least 20 or more hours per week providing Medicaid funded in-home Personal Assistance and Private Duty Nursing services who do not currently have public or private health insurance coverage of any kind. It is estimated that a total of 3,400 Montanans currently work full or part-time as personal care attendants for 30 private agencies and organizations across the state. The results of a recent survey of almost 800 Montana personal assistance workers* are revealing.

- Almost 90% of people working as personal care attendants in Montana are women.
- The average age of a Montana personal care attendant is 44.
- People working as personal care attendants range in age from 15 to 89 years old.
- 21% of personal care attendants are married with children.

● 22% of PCAs are single parents.
● 57% of PCAs are adults without children.
● 20% of personal care attendants are former TANF recipients.
● Personal care attendants are the parents of over 300 children who are currently enrolled in Medicaid and 100 children who are currently enrolled in CHIP.
● The average wage reported by a personal care attendant is $9.05 per hour.
● 80% of personal care attendants have total family incomes under $30,000 per year, which is 150% of the Federal Poverty Level for a family of four.
● Over one-half of the Medicaid personal care attendants surveyed by DPHHS reported that they are currently uninsured.
● Of those who do have insurance, the most common sources of their coverage is their spouse's employer, Medicaid, Medicare, IHS or their parents.
● The two most common reasons given for not having insurance are: "It's too expensive" and "My employer doesn't offer it."

*While the vast majority of the workers surveyed provided Medicaid personal assistance services, the survey results also include the responses of a very small number of private duty nurses.

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

Some Native Americans are employed as personal care attendants; others receive Medicaid funded Personal Assistance Services. Both of these groups will benefit from this proposal. Three Montana tribes currently provide Medicaid Personal Assistance Services through programs they operate and directly administer. Data indicate that the three tribally operated programs report employing approximately 100 Full-Time Equivalent (FTE) personal care attendant positions. Since many personal care attendants work part-time, the actual number of people employed is likely to be much higher. Increasing the number of Native Americans with access to private health insurance will not only give these individuals a way to pay for the important and necessary medical services they themselves require, but it should also act to mitigate the demands placed on the limited resources available through other health care programs such as Indian Health Services (IHS).

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

Montana has recently taken a number of steps to expand the availability of health insurance to low-income children through CHIP and Medicaid. However with the exception of the premium incentives and assistance available under the new Insure Montana program - and the limited amount of proposed adult coverage called for in the recently submitted Medicaid HIFA Waiver - the state has not

been as successful in decreasing the number of working adults who are uninsured, especially those with low-incomes. The proposal outlined in this document offers Montana a golden opportunity to significantly increase the number of low-income working adults who have health insurance in our state and do so with the federal government paying almost 70% of the cost through the Medicaid program. Because the program is funded through the existing Medicaid reimbursement system it avoids the pitfalls and barriers that have derailed attempts to use Medicaid to expand coverage to low-income workers in the past. Some advantages of the current proposal over past efforts include:

●The proposal would use Medicaid funding without changing the state's Medicaid eligibility criteria and thereby avoids the fear that other similar initiatives have historically evoked - that we are somehow expanding eligibility for, and the cost of, an uncontrollable entitlement program;
●The proposal would not require an administratively complex - and sometimes controversial - waiver from Medicaid;
●The proposal would provide health insurance coverage to a significant number of adults who do not have children, a group that is very difficult to serve using Medicaid funding under ordinary circumstances;
●The proposal's use of employer- based coverage is simple and straightforward and builds on an existing public/private partnership rather than creating a new publicly funded and administered program; and
●Because the proposed coverage is not an open-ended entitlement, the state's expenditures for personal care attendant health insurance could be managed in a way that ensures they would remain within the amounts appropriated by the Montana Legislature.

If one of Montana's policy goals is to assist its hard working low-income citizens in accessing high quality affordable health insurance it is difficult to imagine a more deserving group than the Medicaid personal care attendants. In addition to the obviously important nature of the work they do and the services they provide, Montana's personal assistance workforce is an especially compelling group to insure for several other reasons.

●Currently, many of the people who leave the state's TANF program take jobs as personal care attendants, but when they do they generally lose their Medicaid benefits. If they get sick they may have no choice but to quit their jobs in order to regain their Medicaid eligibility. It is likely that the specter of the loss of their Medicaid coverage deters many people from leaving TANF to go to work in the first place. Providing a meaningful health insurance benefit through their employers will enable personal care attendants to continue to work rather than return to Medicaid, and will provide an additional incentive for more people to go to work and get off and stay off welfare.
●The 800 personal care attendants who responded to the survey have a total of over 400 children who are enrolled in either the Medicaid or CHIP healthcare

programs. Research on the utilization of healthcare services indicates that sick children are taken to the doctor sooner and more often when their parents are insured than are the children of parents who are uninsured.
●The number of children (of the workers who responded to the survey) reported as being currently enrolled in the CHIP program appears to be relatively low given the large percent of these families with incomes under 150% of FPL. The plan described here could easily include an outreach component to help locate and enroll any of their children who might be eligible for the CHIP program, in addition to enrolling their parent(s) in the proposed private insurance coverage.

Administrative Issues:

A specific proposal is being prepared for the 2007 Legislature to consider. If unsuccessful, this idea should continue to be explored in the future.

The proposal includes a number of administrative requirements aimed at ensuring that any insurance coverage provided is affordable to the employer and the personal care attendant, and includes healthcare benefits that are similar in scope and quality to those currently available to other Montanans who have health insurance. The proposal would also include administrative procedures/controls that guarantee that the additional funds would only be used to pay for health insurance for the targeted employees. These and other important administrative issues are being reviewed and considered by a work group. The work group has continued to meet.

Preliminary recommendations from the work group regarding some of the important administrative aspects of the proposal include:

●The State Insurance Commissioner's Office in consultation with other program experts, would designate the specific characteristics of the health insurance that an employer must make available to their direct care workers in order to qualify for the additional funding;
●In order to be as cost effective as possible the plan calls for examining the potential of holding down premium costs by looking into the possibility of either accessing an existing health insurance purchasing pool such as Insure Montana, or perhaps creating a new pool (or other cost savings mechanism) designed specifically to insure the workers covered under the proposal;
●Each participating provider agency would only be reimbursed for the actual cost of the monthly health insurance premiums for their eligible employees, up to a maximum average amount per individual to be designated;
●In order to be eligible for insurance an employee would need to work an average of twenty or more hours per week;
●In light of their low wages, and in order to maximize their participation and enrollment, it is the recommendation of the work group that personal care attendants not be required to pay a monthly premium if they elect to enroll in

employee only coverage, or if they are charged a premium that the amount be small;
●If the employee elects to cover his or her spouse or their family through their employer's policy they will be responsible for paying 100% of the additional monthly premium cost;
●At least initially, the Medicaid reimbursement for health insurance will be paid outside the existing Medicaid Personal Assistance and Private Duty Nursing fee-for-service rates in order to isolate and manage these expenditures and ensure the additional funding is used only for its intended purpose; and
●The program would be totally voluntary - provider agencies who do not want to participate would not be required to do so.

Cost

There are two variations of a proposal implementing Healthcare for Montanans who provide Healthcare to be considered. The variations were based on two possible scenarios:

Option #1 – Provide the funding necessary to offer insurance to only those personal care attendants who work an average of 20 or more hours per week; or

Option # 2 – Provide the funding necessary to offer insurance to only those personal care attendants who work an average of 30 hours or more per week.

PROJECTED COSTS

OPTION #1: Direct Care Workers must work at least 20 hours per week.

	FY2008	FY2009	Biennium
Total:	$4,077,708	$9,174,843	$13,252,551
G.F.:	$1,290,187	$2,945,125	$4,235,312
Federal:	$2,787,521	$6,229,718	$9,017,239

Estimated Number of Direct Care Workers Insured: 1,700

OPTION # 2: Direct Care Workers must work at least 30 hours per week.

	FY2008	FY2009	Biennium
Total:	$2,397,767	$5,394,975	$7,792,742
G.F.:	$758,654	$1,731,787	$2,490,441
Federal:	$1,639,113	$3,663,188	$5,302,301

Estimated Number of Direct Care Workers Insured: 1,000

Note: The work group plans on conducting another survey of Medicaid personal care attendants and private duty nurses in order to update the original cost estimates after the preliminary recommendations regarding the exact nature of the insurance coverage and specific requirements for a worker to be eligible to participate are made.

Funding Sources

The proposal is funded with Medicaid at the state's FMAP rate of approximately 68% federal funds/32% state funds.

Implementation

Implementation would necessitate the work group defining what would have to be accomplished legislatively and within State Government to accomplish the goals of this effort.

Recommendation 4B: Extend Age of Dependent Child Coverage to 26

This proposal would change Montana Law to require that all insurance carriers who offer health insurance in Montana must give parents the option of continuing to cover their children as dependents on their family's health insurance policies up to the child's 26th birthday, regardless of the child's employment status or whether or not he or she is enrolled in an educational institution. The requirement would not apply to employers who are self-insured, but would apply to the State Employee Health Insurance Benefits Plan.

Target Population

All Montanans ages 19 through 25 who do not have health insurance are the target population.

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

The proposal would give the parents of uninsured young Native American adults the option of continuing to cover their children on their family's health insurance policy, if they have such insurance. However, the results of the survey done as part of the Montana State Planning Grant in 2003 indicate that 38% of Native Americans living in Montana are uninsured compared to a rate of 19% for the total Montana population. While the number of Native Americans able to take advantage of this proposal may be relatively small, even a modest increase in the percentage of young Native American adults with access to private health insurance should reduce the demand placed on the limited resources available through the Indians Health Services (IHS).

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

A May, 2006 Issue Brief by the Commonwealth Fund titled, "Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help" examines the problem of the rapid increase in the number of young adults ages 19 to 29 who are uninsured. The report attributes the large number of uninsured in this age group to several factors including the steady decline in the availability of employer-based health insurance and the disproportionate impact of this downward trend on the insurance status of young people who are just entering the workforce.

Also contributing to the increase in the number of uninsured young people is the fact that the policies currently available through most insurance carriers do not permit parents to continue to cover their dependent children beyond age 18 or 19, unless they are attending college full-time.

Among the other troubling statistics from the issue brief that highlight the depth and significance of the problem of uninsured young adults are the following:

1. Young adults ages 10 to 29 are one of the largest and fastest growing segments of the U.S. population without health insurance;
2. In 2004 a total of 13.7 million people from this age group were without health insurance, an increase of 2.5 million since 2000;
3. Nearly two of five college graduates and one-half of high school graduates who do not go on to college will be uninsured for some period during the first year after graduation;
4. Forty percent of part-time students or non-students are uninsured compared to only twenty percent of full-time students;
5. Forty-three percent of workers ages 19 – 29 who earn less than $10 per hour are uninsured; and
6. A 2004 survey by Commonwealth indicates that 60 percent of the policies offered by employers do not include coverage of dependent children over the age of 18 if they do not attend college.

In order to address the issue of the significant increase in young adults who are uninsured, states have recently adopted, or are now considering, legislation that would enable parents who wish to do so to continue to cover their young adult children as dependents on their family's health insurance policy, even when they are not full-time students. A diverse group of states including Colorado, Massachusetts, New Jersey, New Mexico, South Dakota, Texas and Utah have already passed legislation raising the age of dependency for most young adults for purposes of eligibility under private insurance plans. The National Conference of State Legislatures reports that a significant number of other states are in various stages of proposing and considering similar legislation.

Montana has already taken many positive steps to increase access to affordable employer-based health insurance through the tax credits, incentive payments and the small business purchasing pool available under the new Insure Montana program. It only makes sense to join these other states and pursue legislation that raises the age of dependency for health insurance, and decouples eligibility for insurance from enrollment in higher education.

While young adults are a relatively healthy age group, if they do become ill they face many of the same tough choices and challenges that confront other people who are uninsured, especially those who work at lower paying entry level jobs. Lack of insurance and other financial resources frequently forces them to delay

or forego necessary medical care until they are so seriously ill that treatment is unavoidable. When they do seek care it is likely to be in the form of unnecessarily expensive treatment in an emergency room - medical care for which the hospital is not reimbursed. In an all too familiar pattern, this uncompensated care then helps drive up the cost of the premiums for others, including employers and those who are lucky enough to have health insurance.

Another payment source for the medical bills of some uninsured young adults is for parents to help cover the cost of their son or daughter's care out of their own pockets. While this may be an acceptable solution when the cost of care is relatively low, if the illness is serious or chronic the parents may be forced to use a significant portion of their life savings in order to be sure that the child they have raised and continue to love receives the full range of prompt and appropriate medical care that they require. This is clearly a case of the solution to one problem creating a new and different problem.

The Commonwealth Fund Issue Brief identified another, somewhat more subtle, negative impact to which young uninsured adults are particularly vulnerable. Young adults who become uninsured lose their ties to primary physicians and the health care system at precisely the time they should be learning to assume responsibility for their own health care. For example, only one-third of uninsured young people ages 19 to 29 who were surveyed had a regular doctor, compared to 81 percent of those who were insured all year. Uninsured male young adults had "the most fragile link to the health care system" with only 21 percent of those surveyed having a regular doctor, compared to 75 percent of young males who had insurance. The failure of young people to learn how to take responsibility for seeking and receiving necessary health care in early adulthood (especially preventive care) could have serious negative consequences for the health and well being of these individuals later on in life, in addition to the obvious potential such behavior has to substantially impact the total cost of healthcare for the rest of us.

While giving more parents the option of continuing to cover their young adult children on their family's health insurance policy for a longer period of time will not totally solve the larger problem of the uninsured in Montana, it is a small step in the right direction that the state can and should take.

Administrative Issues

The proposal may require that the State Insurance Commissioner's Office develop administrative regulations to implement the new definition of dependent.

Cost

The proposal will not require an appropriation of state or federal funds.

Funding Sources

In most cases the additional premium cost will be paid by the parents and/or the young adults who will be insured. Employers will not be required to pay any of the cost for the additional coverage.

Implementation

While there has been some concern expressed by insurers about the New Jersey Law that raised the age of an eligible dependent to 30 years old, there appears to be support from insurance carriers for the more modest changes in the definition of dependent (increases to ages 25 or 26) that have been made in the other states.

In a September 17, 2006 article in the New Your Times, Susan Pisano, a spokeswoman for the industry group America's Health Insurance Plans, said that while insurance companies generally did not oppose laws extending the age limit by a couple of years, New Jersey's law, with an age ceiling of 30 may go too far.

"The law in New Jersey has the potential to drive up health care costs for employers, whereas the other ones do not depart as radically from the current situation in those states," Ms. Piano said. "Our members are comfortable with what is going on elsewhere."

Recommendation 5A: Primary Prevention of Chronic Diseases

Establish a demonstration project at the local public health department level to show feasibility of having these local service delivery sites serve as referral sites for physician-referred patients at high risk for diabetes and those with multiple cardiometabolic risk factors. The goal would be the primary prevention of chronic diseases.

Target Population

Montanans at high-risk for diabetes and Montanans with multiple cardiometabolic risk factors are the target population.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

If an effective primary prevention program (of the Diabetes Prevention Program[1] or Finnish type[2]) had been instituted in MT beginning in 1990, the number pf persons with diagnosed diabetes in MT in 2003 would have been approx. 29,000 (prevalence 4.2% of adults) instead of approx. 38,000 (prevalence 5.5% of adults). This 1.3 percentage point difference (relative difference = 24%) in diabetes prevalence would lead to fewer hospitalizations, less heart disease, fewer premature deaths.

If the prevalence of diabetes in adults in MT were 4.2% rather than 5.5%, (and the quality of secondary prevention efforts had not changed) it would be possible to calculate:

(1) how many premature deaths could be avoided;

(2) how many, and what type of, hospitalizations could be avoided (for diabetes, cardiovascular disease, stroke…);

(3) how many cases of amputation or renal failure might be avoided; and

(4) how many cases of retinopathy and blindness might be avoided.

Administrative Issues

Having staffing and financial support to manage and implement the program are significant administrative issues.

Both writing and "dispensing" exercise prescriptions eventually need to be reimbursable events. It would be ideal if Medicaid and some private payors could be persuaded to pay for this during the demonstration project in the counties that are participating.

Cost

$100,000 per year per pilot site@ 2 sites = $200,000.

Funding Sources

Funding sources are not known at this time.

Implementation

Physician offices would need to recognize and refer patients at "high-risk." High-risk patients could include persons with pre-diabetes, impaired glucose tolerance, impaired fasting glucose, women with a history of gestational diabetes, and persons diagnosed with multiple cardiometabolic risk factors. Many Montanans meet these criteria. Use of an office-based system that tracks patient care and critical indicators would help. Receiving regular feedback from the health department about referred patients would be important.

The local public health agencies would need to be responsive to both physician office and patients referred and would likely need staffing (1.5 to 2.0 FTE) as follows: 1) 0.5-1.0 FTE program assistant to answer phone, take referral information, follow-up with patients who are referred, and assure feedback to physician offices and 2) 1.0 FTE Physical Activity/Diet specialist to see and advise referred patients during home visits and by phone.

High-risk patients would be counseled and assisted to increase physical activity level and decrease fat intake.

Evaluation would include:

(1) Efficiency of identification and referral of patients at physician offices. The Public Health & Safety Division (PHSD) would work with physician offices to do this;

(2) Completeness of "filling" and "following" exercise prescriptions. PHSD and Local Health Departments (LHD's) would work on this;

(3) Weight loss in referred patients. PHSD, LHDs and physician offices would do this and compare to results of other published studies or, potentially, a control group of patients identified in Medicaid/ other payors' patient populations;

(4) Adequacy of feedback to physician offices. PHSD would work with physician offices on this.

References

1. Diabetes Prevention Program Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med 2002;36(6):393-403.
2. Tuomilehto J, Lindstrom J, Eriksson JG, et al. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. N Engl J Med 2001;344:1343-1350.

Recommendation 5B: Integrate Incentive-Based Wellness into Employer-Based Health Insurance

Integrate wellness activities whose results become incentivized (for the employee) into employer based health insurance.

Target Population

State of Montana employees would be the target population.

Support/Rationale

Traditionally the "health care" system is really a sickness based system; this proposal is to refocus some of those efforts from sickness to wellness. By integrating wellness into employer based health insurance overall costs for the employer and the employee can be reduced; the health status of the employees can be improved; employee productivity can be increased; and quality of life of the employees can be improved.

Integration of wellness into employer based health insurance is a several year process before tangible results can be measured. We believe that once they can be measured, they can be replicated to other employers (large and small).

Administrative Issues

The major administrative issues are:

- Union negotiations;
- Reliable administration and tracking of comprehensive health risk assessments;
- Revisions to the current wellness programs for state employees; and
- Integrating health risk assessment into the claim payment system for proper administration and tracking of costs compared to health risk assessment.

Cost

The initial cost will be $20 per month for every employee who chooses to participate in the first year. After that the on-going costs for wellness will be funded by increased cost sharing in the health insurance program. Assume 20% of the roughly 9,000 state employees participate. The annual cost would be $432,000 for the first year. Health risk assessments assume cost is $100 per participant each year, or $180,000, assuming 500 new participants each year.

New funding for the wellness office in Department of Administration increased by $200,000 for programs, not staff.

Year	Wellness Fund	Health Assessments	Wellness Office	Total Costs
1	$432,000	$180,000	$200,000	$812,000
2	NA	$230,000	$200,000	$430,000
3	NA	$280,000	$200,000	$480,000
4	NA	$330,000	$200,000	$530,000
5	NA	$380,000	$200,000	$580,000

Funding Sources

General fund, state special revenue, and federal funds as appropriate would be required.

Implementation

Year 1 Request volunteer participants.
Administer health risk assessment by participant.
Fund wellness fund for individual participant using $20 per month, self directed.
Re-organize and implement new wellness programs for employees – to include smoking cessation, weight management, disease management and fitness.

Year 2 Re-administer health risk assessments by participants and compare to prior year.

Revise benefit plan to have three levels of co-payment and deductible
Gold - $10 office visit co-pay, $10 RX co-pay, and $500 deductible
Silver - $20 office visit co-pay, $20 RX co-pay, and $1,000 deductible
Bronze - $30 office visit co-pay, $30 RX co-pay, and $2,000 deductible.

Employees with a wellness score in the top 20%, or employees who had a 10% improvement in wellness score are given **Gold level** benefits.
Employees with a wellness score in the top 50%, or employees who had an improvement in wellness score are given **Silver level** benefits.
Employees with a wellness score in the bottom 50%, or employees who had a decrease in wellness score, or employees who choose not to participant are given **Bronze level** benefits.
Continue to fund wellness fund for individual participant; use $20 per month, self directed approach.
Request more volunteers; new participants are automatically given **silver** level benefits.

Years 3 thru 5 Continue same procedure as year 2.

Effectiveness Measurement

- Overall improvement in health risk assessment for participants.
- Compare health costs for employer and employee for participants.
- Compare absenteeism for participants and non-participants.
- Assess the quality of life impact for employees.

Recommendation 6: Expand Services Through CHCs

Support efforts to develop more federally funded Community Health Centers and expand medical, dental, and mental health services and delivery sites through existing Montana Community Health Centers.

Target Population

The target population for Community Health Centers is all residents of the state (of all ages) who have incomes under 200% of poverty; and uninsured, underinsured, and underserved Montanans.

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

Indian tribes or tribal or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act are eligible to apply for federal Community Health Center funds. Rules for state funding must define these groups as eligible for services, as well.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

Community Health Centers (CHCs) are private, not-for-profit, consumer-directed health care corporations that receive a federal grant under the U.S. Public Health Service Act to provide comprehensive primary and preventive medical, dental, and mental health care. Clinic fees are based on the patient's ability to pay (sliding scale).

CHCs typically have a multidisciplinary staff - physicians, nurse practitioners, physician assistants, nurses, therapists, dentists, and support workers. Services include primary care visits; health education; disease screening; case management; laboratory services; dental care; pharmacy services; mental health and substance abuse counseling; and social services. Some offer evening and weekend hours for working families, provide care at multiple sites, use mobile clinics to serve hard-to-reach populations, and may employ multi-lingual staffs. All CHCs have a 24-hour system for after-hours calls and emergencies.

These clinics are also commonly referred to as Federally Qualified Health Centers (FQHCs) because they meet rigorous federal standards related to quality of care, as well as cost, and they are qualified to receive reimbursement under Medicaid and Medicare law that is based on their cost of providing care.

Community Health Center dollars flow from the federal government directly to Montana community boards that have policy-making authority and responsibility for the center's management. At least 51% of a health center board must be comprised of patients who utilize the health center's services. Such boards also

include local business, civic, and community leaders and others who bring expertise and experience. Each board ensures that health center services are tailored to the unique needs of that community.

Most of the CHCs in Montana are independent entities, organized as 501(c)(3) not-for-profit corporations. Understanding that there will never be enough federal dollars to address all local health care needs, the federal Bureau of Primary Health Care developed the Community Health Center model around collaboration and partnership. CHCs have close relationships with all public and non-profit health-related service providers in their area, as well as many private providers, and have developed cost-effective and resource-sharing approaches to address the needs of their patients. For example, hospitals and specialists in many areas provide discounted services to CHC patients. These partnerships, which focus on keeping CHC patients healthy and without need of hospitalization, reduce the incidence of uncompensated, complex care.

A strong system of community health centers in strategic geographic areas of the state can significantly address the needs of many Montanans without access to health care and who are not insured. 325,617 (37%) residents of Montana have incomes below 200% of poverty. The average annual salary in Montana is $24,264, ranking 50th in the nation. More than 53,000 of 228,170 Montana children live in poverty. In eleven Montana counties, more than 1 in 5 residents have incomes at or below 100% of poverty (the very poor). More than 1 in 3 Montanans would be eligible for CHC sliding scale discounts for primary and preventive care.

173,000 (19.1%) of all Montanans are uninsured, the 4th highest uninsured rate in the nation. Even if a resident has health insurance, the amount they have to pay out-of-pocket is on the rise. Employers and employees are paying more for less coverage, co-pays are increasing, and deductibles are rising. Many people can only afford to buy “catastrophic only” policies which have high deductibles but protect the buyer in the event of a major illness or injury. These plans do not cover preventive care, health maintenance, or management of chronic diseases or conditions. Because the buyer must pay for those services out-of-pocket, catastrophic only policies may contribute to delayed detection of medical problems, poor management of health conditions, and subsequent health care cost increases. For Montanans who cannot afford to purchase health insurance, Community Health Centers offer a “medical home” and a viable option to access affordable, quality health care.

In 2005, one in four Montanans reported not having a personal health care provider. Fifty-four percent (54%) of Montana’s population reside in areas that have been federally designated as medically underserved or health professional shortage areas. Access to dental care is increasingly difficult as dentists residing in rural and frontier areas retire and it becomes hard to replace them. Fourteen

counties have no dentists or no dentists participating in Medicaid and an additional 14 counties have only one Medicaid enrolled dentist. Access to mental health services is difficult in rural and frontier areas, as well, with 50 of 56 counties having federal designations as mental health shortage areas and only eight counties having psychiatrists. Community Health Centers offer medical, dental, and mental health services. They have opened six satellite clinics in frontier communities and welcome Medicaid and Medicare patients.

In calendar year 2005, 1 in 12 Montanans (76,520) received care at a Community Health Center.

Administrative Issues

The program is currently proposed to be attached to the State of Montana for administrative purposes. An advisory group with members from the Montana Primary Care Association, Montana Community Health Centers, the State Medicaid Director, and members of the Montana House and Senate would guide the development of the program, the application process, and the structure for grant review and award. Grants would be awarded on a competitive basis.

Cost

It would be necessary to appropriate $2 million in fiscal year 2008 and $2 million in fiscal year 2009 to be allocated to the following grant categories:

A.) $1 million per year in competitive grants to create two **new start** non-federally-funded Community Health Centers. <u>This appropriation is intended to support the approved facility until federal funds are granted</u>. With a sliding scale primary care clinic up and running, a Montana community will be at a distinct advantage to compete for federal funds. Successful applicants are expected to apply for Federally Qualified Health Center Lookalike status in addition to receiving state grant funds. This will allow them to receive enhanced reimbursement from Medicare and Medicaid. They will then be expected to apply for a federal Community Health Center grant which, in addition to the federal funds, will provide Federal Tort Claims Act malpractice coverage and access to public health prescription drug pricing. The remaining funds in this category for the biennium may be used for additional new Community Health Centers, if sufficient, or used for expansion of services at existing facilities.

B.) $450,000 for each year of the biennium to provide for **medical, mental health, and/or dental service expansions** to existing Federally Qualified Community Health Centers and others including Certified Rural Health Clinics who have received Federally Qualified Health Center Lookalike status. Funds will be awarded through competitive application.

C.) $450,000 per year to provide grants to existing Federally Qualified Community Health Centers and Federally Qualified Community Health

Center Lookalikes for **capital expenditures** (renovations, expansion of facilities, or equipment). Expansions may include the development of new clinic sites in areas previously not served by a CHC clinic.

D.) $100,000 for each year of the biennium to provide for a contract for the provision of technical assistance to new and existing Federally Qualified Community Health Centers in their efforts to apply for federal funds or expand services, and to collect standardized data on the provision of services to low income and uninsured Montana residents. The contract will provide for an annual report from the Montana Primary Care Association on the technical assistance provided, data collected, and status of applications for federal CHC funding.

Funding Sources

Funding for this proposal could be found in state general fund, coal tax, cigarette tax, or the Tobacco Master Settlement Agreement.

Implementation

State funding for the new and expanded Community Health Centers is intended to continue to support this model of care into the future, facilitating increased access to affordable primary and preventive care.

The program would be implemented as outlined, above. Adherence to the federal Community Health Center model will be required. Through independent and governmental studies, this model has been shown to serve those most in need, to improve access to care, to provide high-quality care, and to provide cost-effective care. Both the Institute of Medicine and the federal Government Accountability Office have recognized Community Health Centers for their effectiveness in managing chronic diseases.

The proposed state funds would support 16,800 primary care visits to around 8,400 Montanans, annually. These funds are intended to be ongoing state support for Montana Community Health Centers.

If unsuccessful in the 2007 Legislature, the state should continue to explore ways to build and strengthen the care system in Montana in the future.

Recommendation 7: Continue Support for Insure Montana

Continued support of Insure Montana is one way to provide coverage and expanded access to affordable healthcare to Montanans—specifically small businesses, their employees, and families.

Target Population

One in five Montanans do not have health insurance. This is upsetting, but even more troublesome is the fact that 53% of Montana's uninsured population works full time for small businesses, the target population of this recommendation.

Montana is a small business state, with most of its companies employing fewer than 10 people. Many of these small businesses simply can't afford to provide insurance, in part because they don't have enough employees to seek competitive rates. And yet 80% have said they would like to provide insurance to their employees, if only they could afford to do so. This program helps fill that gap by making health insurance more affordable for small businesses.

Small businesses that meet a few minimum requirements may qualify for the program. Businesses that have between two and nine eligible employees where no employee makes more than $75,000 (excluding the owner) meet the initial criteria.

40% of the available revenue is directed to refundable tax credits offered to small businesses, many of whom are in danger of dropping their current health insurance plans as a result of rising premiums. The average yearly tax credit amount per small business is $4,917.

60% of the revenue is directed into a purchasing pool, in the form of monthly premium incentive and assistance payments, allowing potentially hundreds of previously uninsured small businesses, and thousands of employers and employees to band together and provide affordable health insurance. 408 businesses (2550 Montanans) have insurance coverage starting November 1, 2006 or before.

Insure Montana is continuing to grow rapidly in enrollment. This funding cycle, it is estimated that the program will cover between 4,000-6,000 Montanans in the purchasing pool and over 3500 Montanans through the tax credit.

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

The initial statewide outreach conducted to inform Montana small businesses about how to enroll in Insure Montana included stops in many areas with a high Native American population percentage.

Additionally, enrollment for Insure Montana has spanned all across the state, with businesses represented in 119 towns or cities.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

The majority of uninsured Montanans work full time for a small business with 10 or fewer employees, and because employer-based health insurance continues to be the primary delivery method for health insurance, it makes sense to enact policies that help small business owners and their employees afford coverage. Insure Montana does just that by allowing previously uninsured small business employers and employees to pay as much as they can afford of a monthly premium, with state tobacco tax revenue filling in the gaps. Insure Montana also allows currently insured small businesses struggling to afford their policies to maintain coverage by making available a refundable tax credit to employers.

Insure Montana has businesses signed up in 119 cities and towns around the state, which demonstrates the statewide interest in the program.

The majority of individuals receiving premium assistance payments through the Insure Montana purchasing pool fall in these income ranges:

Single individuals: $9,570-$19,140 (80-90% assistance)
Married (with no children): $38,490 + (20% assistance)
Single with children: $0-$16,090 (90% assistance)
Family: $29,025-$38,700 (70% assistance)

The average income of Insure Montana individual enrollees falls slightly below Montana's average income of $26,857. We can reasonably conclude that Insure Montana is capturing the lower-middle class that are not eligible for Medicaid or CHIP, but can't afford current market-rate health insurance. Insure Montana builds the bridge to health care affordability—allowing small business owners and employees to pay as much as they can afford. Although Insure Montana is not currently able to access Federal matching funds, there is a substantial "match" when the employer and employee contributions to the total premium are taken into account.

The goal of achieving health care for all Montanans by state policy makers will most likely be achieved by taking a comprehensive approach—on the one hand expanding public programs such as Medicaid, CHIP, and Community Health Centers, and on the other hand through public/private partnerships such as Insure Montana that reach uninsured populations in the employer-based market.

This program has made it possible for more than 2,500 uninsured Montanans to start receiving health coverage through the purchasing pool. Another 682 businesses are already receiving tax credits that assist them in maintaining the health coverage they offer to 3,577 Montanans. (And this number is growing as the program expands.) That means more than 5,000 Montana men, women and children are already receiving health care coverage that may be lost without the support of Insure Montana, and even more will lose the chance for future coverage. Loss of coverage for these individuals would be detrimental not only to themselves, but to the state as a whole as the costs of the care they will inevitably receive are absorbed by everyone else, driving up the cost of health care and health care insurance for everyone.

Administrative Issues

Challenges to Insure Montana Program in the first year of implementation have included:

- Timeline for program implementation was very short.
- Businesses take longer than anticipated to fill out and return coverage applications for the Purchasing Pool (60-90 days versus the expected 30 days).
- Creating new information sharing database with Department of Administration and Department of Revenue was very complicated.
- Low rates and good coverage must be maintained in a volatile health insurance market.

Cost

Funding for Insure Montana is expected to be maintained at the FY ’07 appropriation, approximately $10 million per year, assuming tobacco tax funds accumulate as expected. The number of Montanans that could benefit from the program at this funding level is estimated at 8,000-10,000. If the Montana Section 1115 HIFA waiver is approved, Insure Montana could serve an additional 1200 employees.

Funding Sources

Funded by a $1per pack cigarette tax passed by voters in the fall of 2004, the program was allocated $13 million for the first two years. The application period for Insure Montana opened last fall and benefits became effective in January 2006 to businesses on a first-come, first-served basis. The legislature allocated $3 million for the first fiscal year of the program to allow for ramp up time and $10 million in the second year once the program is fully functioning.

The State Auditor's Office has requested funds at a level of approximately $20 million for the 2008-2009 biennium to sustain current enrollment and administrative expenses of the purchasing pool and tax credits programs. Funding for Insure Montana is expected to be maintained at the FY '07 appropriation, assuming tobacco tax funds accumulate as expected. Additional funding requests for Insure Montana that the SAO submitted through the EPP process include funding for an additional FTE.

Implementation

Implementation of Insure Montana is well underway and is now benefiting over 6,000 people. A Governing board authorized by H.B. 667 and appointed by Governor Schweitzer and State Auditor John Morrison has selected a carrier for the purchasing pool, designed two benefit plans, and created a monthly premium payment system for employers and employees in a short period of time to make coverage available beginning January 2006 to hundreds of previously uninsured Montanans. By the end of this biennium, it is expected that an additional 1500-3500 lives will be covered by the purchasing pool.

The emphasis of 2007 Insure Montana legislation will be on expanding the infrastructure to allow for new cost-saving mechanisms for existing and future purchasing pool members and expanded access to the pool for uninsured Montanans.

Recommendation 8A: Expand CHIP to 200% FPL

Expand CHIP enrollment by increasing income guidelines to 200% of Federal Poverty Level (FPL)

Target Population

- Uninsured, eligible Montana children below 200% FPL are the target population.

- Based on the most recent data from the 2003 Montana Household Survey, this represents a target population of an additional 13,900 children. The number of additional children estimated as eligible are identified in the following income increments:
    - 2,700 children up to 165% FPL
    - 4,700 children up to 185% FPL
    - 6,500 children up to 200% FPL

      13,900 additional children

- In SFY06, CHIP determined 1,748 children to be ineligible because their family incomes were between 151% and 200% FPL. The income breakdown is as follows:
    - 764 children with income up to 165% FPL
    - 716 children with income up to 185% FPL
    - 268 children with income up to 200% FPL

- When children are determined ineligible for CHIP, the family is provided a list of statewide health care services available to all members of the family based on family income (e.g. Community Health Centers, Migrant Health Clinics, Urban Indian Clinics, National Health Service Corps sites in MT, Caring Program for Children, etc.)

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

- All Montanan families who meet income guidelines and have uninsured, eligible children are included in this recommendation.
- CHIP will continue its focus on clarifying for Native American families the advantages of concurrent eligibility for Indian Health Service (IHS) and CHIP benefits.

- CHIP has completed recent visits to all seven tribal reservations and established contacts with IHS representatives serving those living in Indian Country, as well as urban Native Americans. This outreach is ongoing.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

- Reduces the number of uninsured children in the state
- If implemented, an additional 13,900 Montanan children are estimated eligible for CHIP coverage as identified in the 2003 Montana Household Survey. These are uninsured children in families with annual gross incomes between 151% and 200% FPL.

Administrative Issues

- State plan change.
- ARM change.
- Manual changes.
- System changes.
- Training needs.
- Statewide outreach to Montana families about the increased income eligibility level.
- Ongoing – processing increased number of new applications and annual renewals.

Cost

NOTE: CHIP has offered an RFP for Third Party Administrative services and budget figures will change based on the new TPA contract. The following numbers are based upon the current 'fully insured' CHIP plan and reflect only benefit costs (*insurance premium, dental services, and eyeglasses*)*.*

The annual benefit cost for a CHIP child in SFY 2006 was $1,625.47. The state share of SFY06 benefit costs is projected to be $361 in SFY08 and $368 in SFY09.

Assuming a 70% take-up rate of the estimated 13,900 eligible children, 9,730 children between 151% and 200% FPL could be CHIP eligible. Based on SFY06 benefit costs, the estimated total benefit cost to cover these additional children in SFY08 is $15,815,823 of which the state share is $3,512,694. In SFY09, the estimated total increase is $15,815,823 of which the state share is $3,580,702.

Expanding the CHIP FPL to cover children between 151-200% of poverty exceeds the <u>total</u> federal grant currently allocated to Montana. Unless the Federal Grant Award is doubled, the CHIP increase in FPL would require state funding and need a state appropriation in excess of $15 million per year.

Funding Sources

- Title XXI Federal Funds and State Special Revenue Funds
- CHIP enrollment is “capped” based on federal and state appropriations
- CHIP is not an entitlement program (as is Medicaid)

Implementation

- Draft and submit State Plan amendment.
- Revise Administrative Rules of Montana (ARM).
- Revise CHIP Policy Manual Policy.
- Determine, test and implement appropriate changes to the CHIP eligibility data system.
- Train CHIP Staff.
- Conduct statewide outreach to Montana families to inform them of eligibility changes.
- Process applications and renewals to determine eligibility based on new income guidelines.

Recommendation 8B: Standardize Children's Medicaid to 133% FPL

Raise income standard to 133% of FPL from 100% FPL for Medicaid eligibility in the 6 to 19 children's coverage group.

Target Population

Children aged 6 to 19 are the target population.

How are sovereign, tribal populations living in Indian Country and urban Native Americans woven into this recommendation?

All Montana residents are eligible to apply for benefits.

Support/Rationale: Especially – how does this get us to the goal of health care for all Montanans?

1. Increases number of children eligible at application for Medicaid.
2. Extends Medicaid eligibility to age 19 for children currently eligible at 133% under 0 to 5 children's coverage group.
3. Makes available slots in CHIP currently used by this group of children.

Administrative Issues

State plan change.
ARM change.
Manual changes.
System change.
Possible eligibility FTE need based on caseload increase numbers.
Training needs.
Information dissemination about income standard increase.
On-going, processing increased number of applications and annual redeterminations.

Cost

1. Minimum added cost:
Year 1 CHIP Returns 4632 children X $168.24 X 12 = $9,351,452.16

Note: Per information from CHIP, there are 4632 children who are current CHIP recipients aged 6 to 19 and between 100% and 133% of FPL.

Current services average cost per child per month: $168.24.

2. Maximum added cost estimates:

Assume 1/6 of current 0 to 5 coverage group ages into the 6 to 19 coverage group each year. (1/6 of 8502 = 1417 added each year.) There is a cumulative effect because these 1417 children have the potential to stay on for the next thirteen years. Theoretically, in thirteen years there could be at least 18,421 in the 6 to 19 coverage group compared to the 10, 772 currently in the group.

Year 1	CHIP Returns	4632 children X $168.24 X 12 =	$9,351,452.16
	1st Age In Group	1417 children X $168.24 X 12 =	2,860,752.96
	Total to Add	6049	$12,212.205.12
Year 2	Plus 2nd Age In Group	1417 children X $168.24 X 12 =	2,860,752.96
	Total to Add	7466	$15,072,958.08

Year 13 Total Enrolled In 6 to 19 Group 18,421 children X $168.24 X 12 = $37,189,788.48

(Compare to current 10,772 children X$168.24 X 12 = $21,744,375.36.)

Note: Enrollment numbers used for Medicaid computation were from July 2006
0 to 5 coverage group: 8502 children
6 to 19 coverage group: 10,772 children

(Did not try to specifically estimate and add new applications but assumed those numbers would be included in the annual addition of 1417 children. In reality, coverage declines as children get older and also the CHIP returned children would age out over the next thirteen years so the 4632 would decline to zero.)

Funding Sources

FMAP (30/70) for services, 50/50 administrative.

Implementation

State plan amendment requested. ARM change started.

Policy developed, manual adopted into ARM, system changes and testing.

Staff training.

Information dissemination to parents of children potentially eligible.

Accept applications and determine eligibility with new income standard. Return Medicaid eligibles from CHIP at renewal month. Annual redeterminations of Medicaid for on-going eligibility.

ATTACHMENT 1. Summary comments received at Dec. 1 MetNet Meeting

Comments Received at MetNet Meeting
Verbal and Written Public Feedback
On Health Policy Recommendations from
State Planning Grant on the Uninsured Steering Committee

Friday, December 1, 2006 MetNet Conference/Public Review
All locations: 11:30 am - 1 pm

The December 1 Met Net brought together approximately 32 Montanans (representing local health departments, cooperative health centers, independent insurance agents, insurance companies, Head Start programs, Developmental Disability corporations, Mental Health Centers, Urban Indian Centers, Bureau of Indian Affairs, the Department of Public Health and Human Services, the Primary Care Association, the university system, Montana Health Solutions, and the Billings Clinic) at nine sites: Billings (2 sites), Bozeman, Dillon, Great Falls, Helena, Kalispell, Lewistown, and Missoula.

I. The following reflect verbal comments expressed at the Met Net.

- Difficulty locating CHIP providers; CHIP is slow to pay bills to providers.
- Need for adequate prescription drug program in state sponsored programs such as Medicaid and CHIP as well as in private insurance programs.
- Impressed with DRAFT recommendation on better integrating Native Americans into public health care programs, but behavioral health services are missing from that recommendation.
- Important to assess what the Bureau of Indian Affairs (BIA), Indian Health Services (IHS) and Tribal Health can offer Native American members to better integrate Native American residents into other publicly funded programs, such as Medicaid and CHIP.
- Status of Waiver application: DPHHS in process of responding to questions from CMS; target date for implementation still 7-01-07.
- Still a gap in dental services, i.e., few dentists accept Medicaid; Medicaid payments to dentists are too low; Eastern Montana is lacking enough dentists.
- Eastern Montana is lacking enough mental health professionals.
- Little success in getting physicians to do wellness checks on Head Start children in Lewistown, necessitating the use of very expensive alternatives, such as the Ronald McDonald mobile unit.
- Applaud exhaustive work of the Steering Committee in developing the many DRAFT recommendations.

- If the proposed Community Health Support Act doesn't pass the 2007 Legislature, will this Steering Committee move it forward for future consideration?
- Valuable role of Safety Net, including cooperative health centers, Indian Health Services and others will always be considered a part of the discussion leading to a solution.

II. Below are the responses public participants offered in on the written comment sheets in response to the question, What parts of this reporting out was helpful and/or interesting to you?

- Since part of the purpose of this group is to be a continuing public policy "arm" to advise the state, what areas do you think this group needs to be addressing as they move forward?
- To manage healthcare costs there should be access to affordable, quality primary care and prevention services because:
    - Most Montanans don't make much money.
    - Many Montanans do not have insurance.
    - Many cannot afford insurance.
    - Deductibles and co-pays are on the rise while services covered are decreasing.
    - Many Montanans with insurance have no access to care.
    - More Montanans are paying more out-of-pocket.
    - Prevention and primary care are necessary to stay healthy, identify problems early and manage conditions well. Otherwise, it will cost everyone.
- Cooperative Health Center collaborative role in preventive services is not just through local health departments, but through other avenues.
- The Behavioral Health/Mental Health needs of the Native American population need to be expanded.
- In the paradigm shift to prevention, there's a need to look at services to special populations, such as the elderly and their transportation needs (to facilitate access) for example.
- There are many workforce issues to deal with future trends of population health, such as not enough health care professionals available and those that are often not willing to take Medicaid or CHIP patients.

- When are middle-income people (from $35,000-$55,000) going to be helped and those under 65 with costs to drugs, doctors and hospitals? At this point I'm paying for everyone else and I'm getting very little.
- Medicaid patients who continue to utilize Emergency Rooms (ER's) for primary care instead of utilizing their medical home. Needs to be a stronger emphasis or policy to ensure that occurs.
- ERs make money off the patients. What can state policy do given that it is at cross purposes with prevention?
- Prevention again takes the above into consideration and would be at cross purposes with the recommendations, i.e., with my health insurer; ER visits could cost more.

* END *